

Agency _____ Agency # _____

SUPERVISOR'S REPORT OF INDUSTRIAL INJURY

ORIGINAL COPY TO AGENCY

WORKERS' COMPENSATION COORDINATOR

Employee Name _____

Home Address _____ Zip Code _____

Birth Date ____/____/____ Social Security # _____

Job: Title: _____ Marital Status _____

Date of Hire _____ Home Phone # _____

Injury Date ____/____/____ Time _____ AM
PM

Nature of Injury _____ Part of Body _____
(scratch, cut, bruise, etc.) (finger, hand, ankle, etc.)

Name of Dr. or Hospital _____

Location of Incident _____

How did accident happen? (State specific job being done and what went wrong.
Include machine / tool or object connected with accident.)

Actions necessary to Prevent Reoccurrence _____

If accident was caused by non-state employee or by faulty equipment, give name
and address.

List witnesses to accident _____

Was personal protective equipment being worn? ☐ YES ☐ NO

If yes, what type? (check one or more items below.)

☐ Protective Clothing

☐ Hearing Protection

☐ Foot Protection

☐ Respirator

☐ Eye Protection

☐ Back Support Belt

☐ Head Protection

☐ Other (explain) _____

☐ Seat Belts

Is use of personal protective equipment required for this job? ... ☐ YES ☐ NO

EMPLOYEE'S SIGNATURE _____

DATE REPORTED _____

SUPERVISOR'S SIGNATURE (Please Print) _____

PHONE # _____